



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 153

CERTIFICATE OF DEATH

Reg. Dist. No. 21

000688

1. PLACE OF DEATH: Anne Arundel
 County.....
 City or town..... Riveria Beach
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....
 Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

John B. Armhein

4. Sex	5. Color of face	6. (a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) JULY 4 1929

8. AGE: Years	Months	Days	If less than one day
17	0	3	hrs. min.

9. Birthplace..... BALTIMORE MD. (Town, county, and state)

10. Usual occupation..... SCHOOL BOY

11. Industry or business

MOTHER FATHER 12. Name..... JOHN B. ARMHEIN

13. Birthplace..... BALTO. MD.

MOTHER 14. Maiden name..... RENA ROSSI

15. Birthplace..... NORTH CAROLINA

16. Informant..... JOHN B. ARMHEIN (FATHER.)

Address 1326 S?HIGHLAND AVE.

17. BURIAL Date thereof..... JULY 11/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... SACRED HEART

Location..... GERMAN HILL ROAD

18. Funeral director..... Lilly A. Geilner inc.

Address 403 S. WOLFE ST

19. (Date rec'd by registrar) 7-9-46

2. USUAL RESIDENCE (HOME) OF DECEASED:

For newborn infants give residence of mother)
 State..... Maryland County..... *AA*
 City or town..... Riveria Beach
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

NONE

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... July 7 1946 at 3⁴⁵ P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Accidental drowning

DURATION.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... *Accident* Date of..... 7/7/46

Where did injury occur? *Mt. Pleasant Resd. 4-4-4* (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) *Money Creek*

Means of injury.....

Injured at work?

23. SIGNATURE *Lawrence H. Pauchant, M.D.* M. D. or other

Address *403 S. Wolfe St., Baltimore, Md.* Date signed *7/7/46*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 750

CERTIFICATE OF DEATH

06669

Reg. Dist. No. 25

1. PLACE OF DEATH:
 County Anne Arundel County
 City or town Crownsville, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 28 days
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 Crownsville State Hospital
 How long in hospital or institution? 28 days

3. (a) FULL NAME
 ANDERSON - IDA

4. Sex Female 5. Color or race Black 6. (a) Single, married, widowed, or divorced widow

B. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) 1876 ?

8. AGE: Years 70 ? Months unknown Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace unknown
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business _____

FATHER 12. Name unknown
 13. Birthplace unknown

MOTHER 14. Maiden name unknown
 15. Birthplace unknown

16. Informant Hospital Records

Address Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Cemetery or crematory Mt. Zion Cemetery

Location Baltimore City

18. Funeral director Mrs. Katie R. Williams

Address 322 N. Schroeder St., Balto., Md.

19. Date rec'd by registrar July 21 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1709 Pierce Street
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number _____

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1946 at 12:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1946 to July 28 1946 and that I last saw her alive on July 28 1946

Immediate cause of death

Chronic Myocarditis - General
 Arteriosclerosis

DURATION
 Known to us since 7/1/46

Due to _____

Due to _____

Other conditions Senile Psychosis

Known to us since 7/1/46

(Include pregnancy within 3 months of death)

Major findings or operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury _____ Injured at work? _____

23. SIGNATURE

M. D. or other

Address Crownsville, Maryland Date signed 7/28/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

CERTIFICATE OF DEATH

06670

Reg. Dist. No. 21

1. PLACE OF DEATH:

Anne Arundel

County

Annapolis Md.

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs.

Hospital, Institution, or street address where death occurred:

128 Calvert St Annapolis Md.

How long in hospital or institution? *

3. (a) FULL NAME

Blanch R. Baden

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Colored

Divorced

6. (b) Name of husband or wife

6. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) January 1, 1909

8. AGE: Years Months Days If less than one day
37 6 hrs. min.9. Birthplace Sudley A. A. Co. Md.
(Town, county, and state)

Domestic Work

10. Usual occupation

11. Industry or business None

12. Name George Barnett

13. Birthplace Sudley Md.

14. Maiden name Rebecca Gray

15. Birthplace Sudley A. A. Co. Md.

16. Informant Mrs Bessie Griffin

Address 1409 Madison Ave. Baltimore Md.

17. Burial Date thereof 7/14/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Breur Hill Cemetery

Location West St. Extd. Annapolis Md.

18. Funeral director Mrs Chas. E. Hicks

Address 45 Northwest St. Annapolis Md.

19. Date rec'd by registrar July 13 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

County Anne Arundel Co.

City or town Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 128 Calvert St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

220-22-5598

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 11 1946 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 14 to July 11, 1946, and that I last saw her alive on July 11, 1946.

Immediate cause of death

Heart Failure

Due to

Cerebral vascular accident

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

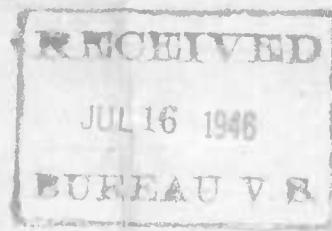
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Date signed 7/15/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-1

CERTIFICATE OF DEATH

06624
Reg. Dist. No. B

1. PLACE OF DEATH: *A.A. Co.*
 County *Pasadena*

City or town *Pasadena P.O.*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *6 mon.*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME *Sarah Gardiner Bean*

4. Sex *F* 5. Color or race *W.* 6. (a) Single, married, widowed, or divorced *S.*

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.) *Oct 6-1890* 6. (c) If alive, give age *years*

8. AGE: Years *55* Months *9* Days *8* If less than one day *hrs. min.*

9. Birthplace *St. Marys Co. Md.* (Town, county, and state)

10. Usual occupation:

11. Industry or business *Robert W. Bean*

FATHER 12. Name *Robert W. Bean* 13. Birthplace *Md.*

MOTHER 14. Maiden name *Julia Gardiner* 15. Birthplace *Md.*

16. Informant *Mrs. Annie Huntington*

Address *3200 Hamilton Ave* Date thereof *7-6-46* (month) (day) (year)

17. Burial (Burial, cremation, or removal. Which?) *Burial* Cemetery or crematory *Woodlawn*

Location *Baltimore Co. Md.*

18. Funeral director *Wm. Cook Inc.*

Address *1217 St Paul Street*

19. *7-16 46 Occupied* (Date rec'd by registrar) 19. *7-15 46* (Date signed) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State *Md.* County *A.A. Co.*

City or town *Pasadena P.O.* (If outside city or town limits, write RURAL and give nearest town)

Street No. *Magoffin Beach Rd.* (If rural, give LOCATION)

2. (a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 17 1946* at *9 AM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 17 1946 to *July 14 1946* and that I last saw her alive on *July 12 1946*

Immediate cause of death:

Cachexia DURATION *3 mo.*

Due to: *pulmonary Tuberculosis.* DURATION *10 years.*

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury *Gherth Mortimer Jr. dec.* Injured at work?

23. SIGNATURE *Gherth Mortimer Jr. dec.* M. D. or other *M. D.*

Address *2706 St Paul St* Date signed *7-15-46*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18/2

06672

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town

Anne Arundel Co.
Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

New long in above place of death? 28 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Pierre J Berger

4. Sex

M

5. Color or race

W

(a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.)

June 30th 1876

6. (c) If alive, give age years

8. AGE: Years

Months

Days

If less than one day

70

0

12

hrs. min.

9. Birthplace

Baltimore Md.

(Town, county, and state)

10. Usual occupation

Refined

11. Industry or business

Singer

FATHER

12. Name

Andrew Berger

13. Birthplace

Baltimore Md

MOTHER

14. Maiden name

Mary A Raymond

15. Birthplace

York P.C.

16. Informant

Mercedes Sanders

Address

211 S 4th St

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 16 - 46

(month) (day) (year)

Cemetery or crematory

Glen Haven

Location

Charles P Howell

18. Funeral director

2427 Edmundson Ave

Address

19. Date rec'd by registrar

19-46

(Date rec'd by registrar)

and placed in

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Anne Arundel Co

City or town

Glen Haven

(If outside city or town limits, write RURAL and give nearest town)

Street No.

211 S 4th St

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 12th 1946 at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

218/46 19. to 7/12/46 19. and that I last saw him alive on 7/11/46 19.

Immediate cause of death

Coronary Thrombosis

Due to

Due to

Open Endocarditis

Cocaine Sclerosis

Other conditions

Chronic Infect.

Chronic Nephritis

Several Years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John J. Magruder

M. D. or other

John Berger

Date signed 7/12/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1642

06674

Reg. Dist. No. 20

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

A.C. *Danversville*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Leorgetta Davis

4. Sex

Female White Married

5. Color or race

6. (c) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Raymond L Davis

7. Birth date of deceased (mo., day, yr.)

Aug 12 1895

6. (c) If alive, give age years

8. AGE:

Years Months Days If less than one day

51 11 1 hrs. min.

9. Birthplace

A. C. Co. Md.

(Town, county, and state)

10. Usual occupation

Home wife

11. Industry or business

John W. James

Pittsboro Co. Md.

12. Name

Connie V. Hardy

A. C. Co. Md.

MOTHER FATHER

B. M. Davis

Danversville A. C. Co. Md.

13. Birthplace

Cemetery or crematory

Location

Means of injury

18. Funeral director

Address

(Date rec'd by registrar)

19. July 15 1946

Carrie Smith

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County

City or town

Danversville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated: ~~Postmortem Examination~~~~July 13 1946~~~~July 13 1946~~

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

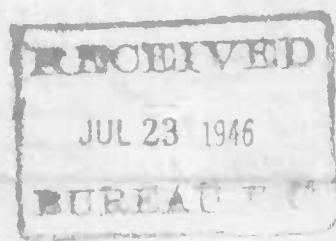
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 7/13/46Where did injury occur? Danversville A. C. Co. Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) at homeMeans of injury hanged by neck Injured at work? NoSignature John M. Caffer M.D. Deputy Medical Examiner M. D. or otherAddress Annapolis Md. Date signed 7/15/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

CERTIFICATE OF DEATH

Reg. Dist. No. 2

06625

1. PLACE OF DEATH:

County: BaltimoreCity or town: Chesapeake Bay

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ralph Diaz4. Sex: Male5. Color or race: white6. (a) Single, married, widowed, or divorced: single

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.): May 19276. (c) If alive, give age: years8. AGE: 19 Years 0 Months 0 Days 0 If less than one dayhrs. 0 min. 09. Birthplace: New York City, N.Y.

(Town, county, and state)

10. Usual occupation: discharged - U.S. Navy 2 weeks ago11. Industry or business: A. S. W.12. Name: Ralph Diaz13. Birthplace: Puerto Rico14. Maiden name: Catherine Monosacki15. Birthplace: Puerto Rico16. Informant: Dr. Andres E. CelasAddress: Baltimore City, Md17. Burial: Burial Date thereof: 7-16-41
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory: Cathedral ofLocation: Baltimore, Md18. Funeral director: George A. TaylorAddress: Salisbury, Md19. Date rec'd by registrar: 7/17/45 1945

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Maryland County: BaltimoreCity or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)Street No. 2535 Avenue: Agnes St

(If rural, give LOCATION)

2. (a) If veteran, name war: World War II

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 12 1946

about 5:20 A.M.

21. I CERTIFY that death occurred on the date above stated: Postmortem Examination

July 13 1946

Immediate cause of death: Strangling

DURATION

Due to: StranglingDue to: Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident

Date of

Where did injury occur? Chesapeake Bay

(City or town)

(County)

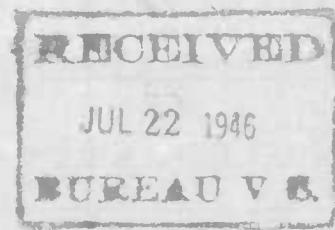
(State)

Injured at home, farm, industry, public place (where?) Chesapeake BayMeans of injury: stranglingInjured at work? no23. SIGNATURE: John M. Claffy M.D.

Deputy Medical

Examiner

Address: Annapolis, Md Date signed: 7/13/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53B

CERTIFICATE OF DEATH

00076

22

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

Anne Arundel
Dorsey

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred.

Forest Ave Nursing Home

How long in hospital or institution?

3. (a) FULL NAME

Edward Clarence Dietz

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

W

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Jan. 2, 1928

8. AGE: Years

Months

Days

If less than one day

18

6

20

hrs.

min.

9. Birthplace.....

(Town, county, and state)

Ellicott City, Md.

10. Usual occupation.....

worked for United St. Ry.

11. Industry or business

Class: E. Dietz

12. Name.....

13. Birthplace

U. S. A. - Md.

14. Maiden name.....

Florence M. Dietz

15. Birthplace

U. S. A. - Md.

16. Informant.....

Mrs. M. Jilek

Address

Forest Ave, Hanover, Md.

17. Burial

Date thereof..... 7-25-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Good Shepherd

Location

Ellicott City, Md.

18. Funeral director.....

J. C. Dryden & Subathorn

Address

Ellicott City, Md.

19. Date rec'd by registrar

July 26, 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.....

County.....

Baltimore City

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 22 1946 at 345 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

11-30 1945 to 7-22 1946

and that I last saw h. m. alive on

July 17 1946

Immediate cause of death.....

Metastasis to Lung

Due to..... Osteogenic Sarcoma

Due to..... of right elbow

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

GASES, LIQUIDS, RADIATION

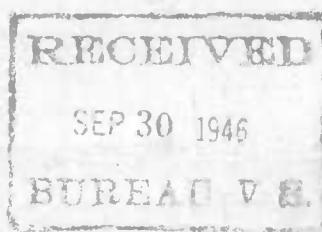
23. SIGNATURE.....

Address.....

718 N. Charles

M. D. or other

7/22/46 Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06677

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yrs

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 12 hrs

3. (a) FULL NAME

James Albert ELDER

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widower

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.) Sept 13, 1881

8. AGE: Years 64 Months 9 Days 27 If less than one day hrs. min.

9. Birthplace Rockville, Maryland
(Town, county, and state)

10. Usual occupation Paper hanger

11. Industry or business ---

MOTHER FATHER	12. Name	William M. Elder
	13. Birthplace	Maryland

MOTHER	14. Maiden name	Lizav Jane Lilly
	15. Birthplace	Maryland

16. Informant	Mrs. Webster King
Address	1 Hill St, Annapolis, Md.

17. Burial	Date thereof	July 13, 1946	
(Burial, cremation, or removal. Which?)	(month)	(day)	(year)

Cemetery or crematory	Loudon Park Cemetery
Location	Baltimore, Maryland

18. Funeral director	BL Hopping & Son
Address	170-172 West St, Annapolis, Md

19. Date rec'd by registrar	July 13 1946	7-12-46
-----------------------------	--------------	---------

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 113 Main St.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH July 10, 1946, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10th 10 A.M. 1946, to July 10, 1946, and that I last saw him alive on July 10, 1946.

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

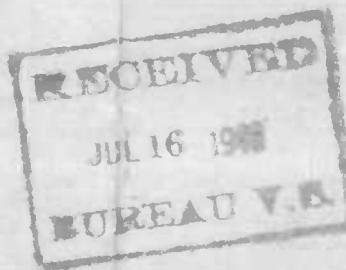
Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C. Bond

M. D. or other

Address Annapolis, Md Date signed 7-12-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *1220*

06679

CERTIFICATE OF DEATH

Reg. Dist. No. *21*

1. PLACE OF DEATH:

County *Anne Arundel*City or town *Annapolis, Maryland*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *2 Hrs*

Hospital, institution, or street address where death occurred:

*Emergency Hospital*How long in hospital or institution? *3 hrs*

3. (a) FULL NAME

*George Henry ELLIOTT*4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*6. (b) Name of husband or wife *Lavinia F. Elliott*6. (c) If alive, give age *62* years7. Birth date of deceased (mo., day, yr.) *July 12, 1878*8. AGE: Years *69* Months *11* Days *29* If less than one day *hrs.* *min.*9. Birthplace *Calvert Co., Maryland*
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name *Algerman Elliott*13. Birthplace *St. Mary's Co., Md.*14. Maiden name *Elizabeth Dunn*15. Birthplace *St. Mary's Co. Md.*16. Informant *Mrs. Lavinia F. Elliott*Address *321 West St. Annapolis, Md.*17. Burial *Burial* Date thereof *July 14, 46*
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *Cedar Bluff Cemetery*Location *Annapolis, Md.*18. Funeral director *B. L. Horning & Son*Address *170-172 West St. Annapolis, Md.*19. *July 13, 46*
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Anne Arundel*City or town *Annapolis, Md.*
(If outside city or town limits, write RURAL and give nearest town)Street No. *321 West St.*

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 11, 1946, 11:30 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*7:15 A.M. 1946, to**7:15 A.M. 1946*and that I last saw *him* alive on *7:15 A.M. 1946**7:15 A.M. 1946*

Immediate cause of death

Intestinal obstruction

DURATION

*5 days*Due to *strangulated int. w/d complete w/g. Pericard*

?

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

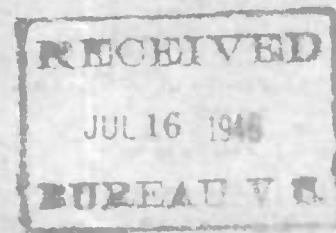
Means of injury

Injured at work?

23. SIGNATURE *J. Brossard M.D.*

M. D. or other

Address *Annapolis, Md.* Date signed *7/12/46*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (16)

06680

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

Anne Arundel
County: Anne Arundel

City or town: (If outside city or town limits, write RURAL and give nearest town) Annapolis

How long in above place of death? 4 or 5 seconds

Hospital, institution, or street address where death occurred: Was dead upon arrival at the

How long in hospital or institution? Emergency Hospital

3. (a) FULL NAME

Harry Evans.

4. Sex: M. Color or race: Colored. 5. (a) Single, married, widowed, or divorced: Separated.

6. (b) Name of husband or wife: Bertha Evans

7. Birth date of deceased (mo., day, yr.): Sept. 3, 1900 6. (c) If alive, give age: years

8. AGE: 45 Years Months Days If less than one day: hrs. min.

9. Birthplace: Annapolis Ind. A.A. Co. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

12. Name: Louis Evans.

13. Birthplace: Ind.

14. Maiden name: Sophia Johnson

15. Birthplace: Ind. H.H. Co.

16. Informant: Frank Evans

Address: Clay St. Annapolis, Ind.

17. Burial (Burial, cremation, or removal. Which?) Brewer Hill Date thereof: July 5, 1946 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: Annapolis, Ind.

18. Funeral director: J.B. Johnson

Address: Annapolis, Ind.

19. Date rec'd by registrar: July 2, 1946 - D. Evans

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother) Maryland County: Anne Arundel

City or town: (If outside city or town limits, write RURAL and give nearest town) Annapolis

Street No: 78 - Franklin St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1st 1946 at 8 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on 19.

Immediate cause of death: Hemorrhage

DURATION: Sunday

Due to: Pulmonary embolism.

Due to: X 32 - caliber Bullet.

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations: Date of op.

Autopsy results: PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: 7/1/46

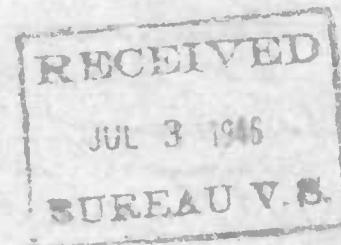
Where did injury occur: Annapolis a.a. 7/1/46 (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) Street

Means of injury: Injured at work?

23. SIGNATURE: Gustav H. Bauchens, M.D. or other

Address: 1010 Biddle St., Annapolis, Md. Date signed: 7/1/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

06678

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County

Baltimore

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John Van Lear Findley

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife

Doris

7. Birth date of deceased (mo., day, yr.)

6 Nov 1880

8. AGE:

66

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual occupation

none Retired

11. Industry or business

John Van Lear Findley

12. Name

Baltimore

13. Birthplace

Baltimore

14. Maiden name

Mary Geesey

15. Birthplace

Baltimore

16. Informant

John Van Lear Findley

Address

307 Alpine Rd. Baltimore

Burial

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Greenmount Cemetery

Location

Baltimore

18. Funeral director

Stern J. Leibner & Sons

Address

Baltimore

19. Date rec'd by registrar

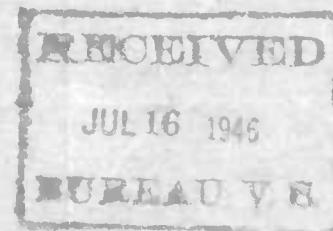
July 13 1946

Date rec'd by registrar

19. Date rec'd by registrar

July 13 1946

Date rec'd by registrar



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

CERTIFICATE OF DEATH

66681

21

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

1. PLACE OF DEATH:

County.....

City or town.....

Anne Arundel

Edgewater (Woodland Beach)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

1 day

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Jane Gallagher

4. Sex.....

female

5. Color or race.....

white

6. (a) Single, married, widowed, or divorced.....

widow

6. (b) Name of husband or wife.....

John Gallagher

7. Birth date of deceased (mo., day, yr.).....

Nov. 26, 1857

(c) If alive, give age..... years

8. AGE: Years.....

88

Months.....

7

Days.....

24

If less than one day.....

hrs.

min.

9. Birthplace.....

Scotland

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business.....

Home

12. Name.....

Samuel Hauer

13. Birthplace.....

Scotland

Ireland

14. Maiden name.....

Jane Luttemans

15. Birthplace.....

Scotland

16. Informant.....

Mrs. Agnes McCarthy

Address.....

412 Freeman St., Baltimore, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... July 23, 1946

(month) (day) (year)

Cemetery or crematory.....

Holly Cross - A.A. County

Location.....

A.A. County - Md.

18. Funeral director.....

West Oak Loco

Address.....

1217 Belair St. Baltimore Md.

19. 7/22 1946

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

City or town.....

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

412 Freeman St

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

July 20

19

46 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; Postmortem Examination was done and cause of death acute dilatation of heart on July 20 1946.

Immediate cause of death.....

Due to.....

Acute dilatation of heart

Due to.....

Senility -

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, Industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

John H. Claffy, M.D. Medical Examiner
M. D. or other

Address.....

Annapolis, Md.

Date signed.....

July 20, 1946

Evidence for change of age
of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

06682

Reg. Dist. No. 21

CERTIFICATE OF DEATH

FILE N.

1. PLACE OF DEATH 06 AUG 13 1946

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hosp.

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife

Ida B. Luenot

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age

years

Aug 20th 1885

8. AGE:

Years

Months

Days

It less than one day

hrs.

min.

60 -60- 10

9. Birthplace

(Town, county, and state)

Baltimore Md

Chef

10. Usual occupation

11. Industry or business

FATHER

12. Name

Francis Luenot

13. Birthplace

France

14. Maiden name

Marie M. Bush

Paris France

15. Birthplace

Paris France

16. Informant

Edward Luenot

Elk Club Annapolis Md.

Bureau

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory

Cedar Bluff

Annapolis Md

Location

John M. Taylor Son

18. Funeral director

Address

Annapolis Md

19. Date rec'd by registrar

July 23 1946

Date rec'd by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

Maryland Anne Arundel

Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 20 1946 at 20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 15 1946 to July 20 1946

and that I last saw him alive on July 19 1946

Immediate cause of death

Carcinoma of Stomach

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

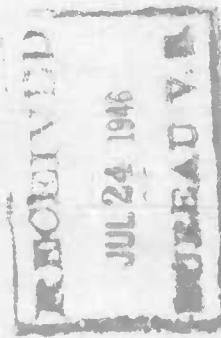
Injured at work

23. SIGNATURE

George C. Rosal M. D. or other

Annapolis Md 7-22-46

Date signed



PLEASE WRITE PLAINLY. WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

06683

1. PLACE OF DEATH:

County... Anne Arundel
City or town... Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hosp.

How long in hospital or institution?

3. (a) FULL NAME

William Thaddeus

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MALE

WHITE

SINGLE

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

July 8, 1946

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

2 hrs.

45 min.

9. Birthplace... ANNAPOLIS, MD.

(Town, county, and state)

10. Usual occupation...

NONE

11. Industry or business

George C. Thaddeus

MOTHER FATHER

12. Name...

Stanley, Pa.

13. Birthplace

14. Maiden name...

Mildred C. Lambert

15. Birthplace

Maryland

16. Informant...

Elton R. Thaddeus

Address

2521 12th St. Wash. D.C.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof... 7-10-46

(month) (day) (year)

Cemetery or crematory

Mt. Hebron

Location

Winchester, Va.

18. Funeral director

John M. Laffey, son

Address

Annapolis, Md.

19. July 9, 1946

(Date rec'd by Registrar)

- O. French

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Wash. D.C. County

City or town... (If outside city or town limits, write RURAL and give nearest town)

Street No. 2521 12th St. Wash. D.C.

(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 8, 1946, at 8:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8, 1946, to July 8, 1946, and that I last saw him alive on July 8, 1946.

Immediate cause of death

Prematurity 5 months

Due to

Premature Labor

DURATION

5 min

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide...

Date of...

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

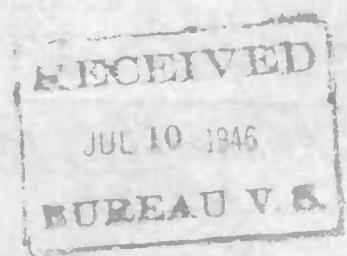
23. SIGNATURE

James R. Martin, M.D.

185 Prince George St., Annapolis, Md.

M. D. or other

Date signed 7-8-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15-2

CERTIFICATE OF DEATH

Reg. Dist. No. 22

06684

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

7 months

Hospital, Institution, or street address where death occurred:

Maryland House of Correction

How long in hospital or institution?

Since 1/1/46

3. (a) FULL NAME

Louis R. Harris

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M. Black Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 2/28/25

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

21 4 23 hrs. min.

9. Birthplace

(Town, county, and state)

Baltimore, Md.

10. Usual occupation

"as robbing"

11. Industry or business

Mortgage Banker

FATHER

12. Name

MOTHER

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

Date

20. Date of death

19

to

19

M

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County 9-a.

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1715 Lombard St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 21

19

46

at

9:05

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw h. alive on

Immediate cause of death

acute congestive
heart failure -

DURATION

sudden.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Lester H. Paesler, M.D. or other

Address 1303 Prestonway St. Date signed 7/27/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 158

06685

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution? 18 hours

3. (a) FULL NAME

Winder W. Hunt

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

M C S

6. (b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.) April 22, 1946

8. AGE: Years Months Days If less than one day
0 2 13 hrs. min.9. Birthplace Jones St., A.A.C., Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Edward W. Hunt

13. Birthplace A.A.C.

MOTHER 14. Maiden name Edan Summerville

15. Birthplace A.A.C.

16. Informant Hospital Record

Address Annapolis

17. Burial Date thereof July 6, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery Hill

Location Jones St., A.A.C.

18. Funeral director T.B. Johnson

Address Annapolis, Md.

19. July 6, 1946 - O. Frank
(Date rec'd by registrar) Registrant

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A.A.C.

City or town Severn P.M.K.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1946, at 3:28 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4, 1946, to July 6, 1946, and that I last saw him alive on July 4, 1946.

Immediate cause of death

Cardio-respiratory Failure

DURATION

Due to Marasmus

Due to Malnutrition

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

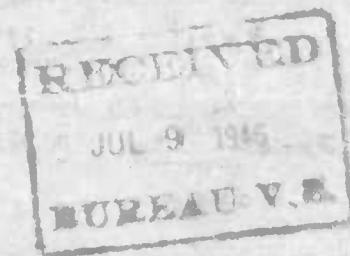
Means of injury

Injured at work?

23. SIGNATURE Edward P. Ritchings, M.D.

M. D. or other

Address 199 Gloucester St. Date signed July 6, 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06686

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

47 Northwest St.

How long in hospital or institution? *****

3. (a) FULL NAME

Catherine Estelle James

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Col. Single

6. (b) Name of husband or wife *****

7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age 19 years

May 27, 1896

8. AGE: Years Months Days If less than one day
50 1 hrs. min.

9. Birthplace Annapolis Md. A. A. Co.

(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business None

12. Name William Thomas James

13. Birthplace Prince George County

14. Maiden name Carrie Sedonia Bias

15. Birthplace Annapolis Md. A. A. Co.

16. Informant Mrs Carrie S. James

Address 47 Northwest St. Annapolis Md.

17. Burial Date thereof 7/7/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Brew Hill Cemetery

Location West St. Extd. Annapolis Md.

18. Funeral director Mrs. Charles E. Hicks

Address 45 Northwest St. Annapolis Md.

19. Date rec'd by registrar July 5 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 47 Northwest St.

(If rural, give LOCATION)

2.(a) If veteran, name war

None

3. (b) Social Security Number

214-12-3638

MEDICAL CERTIFICATION

2D. DATE OF DEATH July 1 1946 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15 1946 to July 1, 1946
and that I last saw her alive on July 1, 1946

Immediate cause of death

Cardiac Failure

DURATION

10th

Duo to Mutual Insufficiency

Duo to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

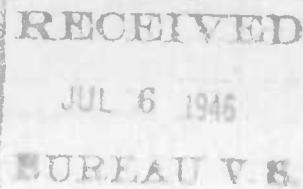
Injured at work?

23. SIGNATURE

Theodore H. Johnson M.D.

M. D. or other

Address 40 Northwest St. Date signed 7/2/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06687

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

Anne Arundel

County

Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred:

Parole Md. A. A. Co.

How long in hospital or institution? *****

3. (a) FULL NAME

Susie Johnson

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female Col. Married

8. (b) Name of husband or wife WM. Henry Johnson

7. Birth date of deceased (mo., day, yr.) December 1873 8. (c) If alive, give age 73 years

8. AGE: Years Months Days It less than one day
70 7 hrs. min.

9. Birthplace Prince George Co. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business None

12. Name Wm. Betters

13. Birthplace Unknown

14. Maiden name Sarah Brooks Betters

15. Birthplace Prince George Co. Md.

16. Informant Mrs Ethel Johnson

Address Parole Md. A. A. Co.

17. Burial Date thereof 7/5/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fowlers Chapel Cemetery

Location Best Gate Md. A. A. Co.

18. Funeral director Mrs Charles E. Hicks

Address 45 Northwest St. Annapolis Md.

19. Date received by registrar July 5 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Parole Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Parole

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 1945 to July 25 1946

and that I last saw her alive on July 25 1946

Immediate cause of death

Myocardial Failure

Due to Chronic Myocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

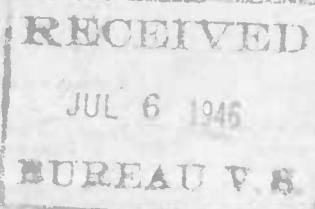
Means of injury

Injured at work?

23. SIGNATURE

R. P. Johnson M. D. or other

Address 1200 7th Street Date signed 7/3/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-5

CERTIFICATE OF DEATH

06688
28

Reg. Dist. No.

1. PLACE OF DEATH:

County Anne Arundel County
City or town Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years, 25 days

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 4 years, 25 days

3. (a) FULL NAME

JONES - DAWKINS (James)

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife Margaret Jones, Palmers.
St. Mary's Co., Md.

7. Birth date of deceased (mo., day, yr.) December 16, 1901

8. AGE:	Years 44	Months 6	Days 26	If less than one day --- hrs. --- min.
---------	----------	----------	---------	---

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name James Darby Jones

13. Birthplace unknown

MOTHER 14. Maiden name Anna Hopps

15. Birthplace Maryland

16. Informant Hospital Records

Address Crownsville, Maryland

17. Burial Date thereof 7/18/46
(Burial, cremation, or removal. When?)

Cemetery or crematory Hospital

Location Crownsville

18. Funeral director Sup. Hospital

Address Crownsville, Md

19. July 18 1946 E. T. Joyce, Jr.
(Date rec'd by registrar) (Signature) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County St. Mary's

City or town Palmer's Post Office
(If outside city or town limits, write RURAL and give nearest town)

Street No. unknown

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1946 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 1942, fo. July 12 1946

and that I last saw h. im. alive on July 12 1946

immediate cause of death

Lung Tuberculosis

DURATION

Known to us since 6/8/46

Due to

Due to

Other conditions General Paresis

Known to us since 6/17/46

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

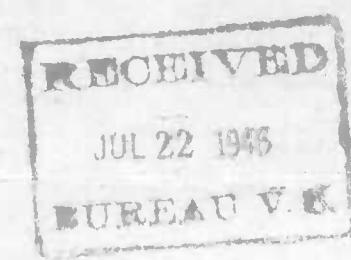
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Crownsville, Maryland Date signed 7/12/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 6

06690

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution? 9 days

3. (a) FULL NAME

Tillie KOTZIN

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife Max Kotzin

7. Birth date of deceased (mo., day, yr.) March 28, 1897

8. AGE: Years Months Days If less than one day
59 3 17 hrs. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Solomon Lawenthal

13. Birthplace Russia

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mr. Herbert Kotzin

Address 22 Steel St. Annapolis, Md.

17. Burial Date thereof July 14, 1946
(Burial, cremation, or removal. Which?) (month) (day), (year)

Cemetery or crematory Kneseth Israel Cemetery

Location Best Gate, A.A. Co. Md.

18. Funeral director B.L. Hopping & Son

Address 170-172 West St. Annapolis, Md.

19. July 14 1946
(Date read by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 239 West St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1946 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 1946 to July 14 1946 and that I last saw her alive on July 14 1946

Immediate cause of death

coronary thrombosis

DURATION

July 3

Due to arteriosclerosis

when

Due to

Other conditions Diabetes mellitus unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

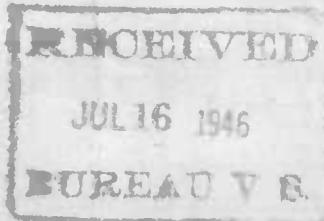
Means of injury

Injured at work?

23. SIGNATURE George C. Boul

M. D. or other

Address Annapolis, Md. Date signed July 14, 1946



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06691

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County ANNE ARUNDEL

City or town RURAL MARGATE - near Glen Burnie
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution

Leymar & Midland Roads, Box 32

Stay in hospital or Inst. (yrs., or mos., or days)

3 yrs

Stay in this community (yrs., or mos., or days)

3 yrs

3. (a) FULL NAME

JOHN WILLIAM LAMBERT

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

EDNA I. LAMBERT
(Wife Spouse)

6. (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.)

JUNE 5, 1899

8. AGE:

Years
47Months
1Days
28

If less than one day

hrs.

min.

9. Birthplace

BALTIMORE MARYLAND

(Town, county, and state)

10. Usual occupation

GUARD & CHAUFFEUR

11. Industry or business

SHIP YARD (Bethlehem)

MOTHER FATHER

WILLIAM J. LAMBERT

13. Birthplace

BALTIMORE, MARYLAND

14. Maiden name

LAURA ALICE

15. Birthplace

BALTIMORE, MARYLAND

16. Informant

MRS. EDNA I. LAMBERT (Wife)

Address

MARGATE, S. D. CO. MD.

17. Burial

Date thereof July 29, 1946
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Anne Arundel Glen Haven Crematory

Location

Anne Arundel Co., Md.

18. Funeral director

A. J. Counsel Evans

Address

400 S. Charles St. Balt. 30

19.

Date rec'd by registrar

7/29/46

A. W. Heffner

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County ANNE ARUNDEL

City or town RURAL NEAR GLEN BURNIE

(If outside city or town limits, write RURAL NEAR and give town)

Street No. RURAL - LEYMAR & MIDLAND Rds.

F'D - #9 (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 26

1946, at 2:00 AM

2f. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Not seen to alive

and that I last saw him alive on

Immediate cause of death Coronary

DURATION

thrombosis

Due to UNKNOWN

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Henry F. Zangara M.D.

M. D. or other

Address Glen Burnie, Md.

Date signed July 26, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

06692

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

Anne Arundel County

Laurel City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/2 years

Hospital, institution, or street address where death occurred:

District Training School

How long in hospital or institution? 2 1/2 years

3. (a) FULL NAME

Raymond Charles Love

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

—

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23 1934

8. AGE: Years 12 Months 0 Days 21 If less than one day hrs. min.

9. Birthplace D. C.

(Town, county, and state)

10. Usual occupation Inmate

11. Industry or business

12. Name JACK LOVE

13. Birthplace RUSSIA

14. Maiden name ESTHER —

15. Birthplace RUSSIA

16. Informant Record of District Training

School

Address Laurel, Md.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof July 15-44

Cemetery or crematory

Location Washington DC

18. Funeral director B. Dalmansky & Son

Address 3501-14th St. NW

19. Date reg'd by registrar July 15 1946

(Date reg'd by registrar) Clara Newby

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

D. C.

County

City or town

Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.

1355 H. Street N.E.

(If rural, give LOCATION)

2. (a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 14 1946 at 8:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 28 1944, to July 14 1946

and that I last saw him alive on July 14 1946

Immediate cause of death

Broncho pneumonia

DURATION

24 hr

Due to

Due to

Other conditions Vincent's Infection

Mongolism

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Alan M. Dunn

M. D. or other

Address District Training School Date signed 7-14-46

RECEIVED

SEP 30 1946

BUREAU V.S.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

STATE OF MARYLAND—CERTIFICATE OF DEATH

1. PLACE OF DEATH

County: Anne Arundel

Village or City: Shady Side

Registration Dist. No.

06693

21

9

Length of residence in city or town where death occurred: 40 yrs.

No. (If death occurred in a hospital or institution, give its NAME instead of street and number)

mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME

(a) Residence: No.

(Usual place of abode)

Gertrude Niemeyer Mangels

If U. S. Veteran, specify WAR

State

Ward

Baltimore, Md.

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Female White

Married

6a. If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Bertha M. Mangels

6. DATE OF BIRTH (month, day, and year)

July 21, 1878

7. AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.

67

11

14 days

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

OCCUPATION

12. BIRTHPLACE (city or town)
(State or country)

Baltimore, Md.

MOTHER

FATHER

13. NAME: Lucy W. Niemeyer

14. BIRTHPLACE (city or town)
(State or country)

Germany

15. MAIDEN NAME: Wilhelma Niemeyer

16. BIRTHPLACE (city or town)
(State or country)

Germany

17. INFORMANT: Louise Niemeyer Mangels
(Address)

18. BURIAL, CREMATION, OR REMOVAL

Place: Oak Lawn Date: July 8, 1946

19. UNDERTAKER

(Address): Paul - Baltimore, Md.

20. FILED: 7-8-46

Deputed by
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

7

(Month)

5

(Day)

1946
(Year)

22. I HEREBY CERTIFY, That I attended deceased from

July 8, 1946, to July 5, 1946

I last saw her alive on July 14, 1946, death is said to have occurred on the date stated above, at 12 m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

coronary occlusion

Date of onset

Other Contributory Causes of importance:

hypertension
atherosclerosis

Date of

Name of operation _____ Was there an autopsy? _____

What test confirmed diagnosis? _____

Where did injury occur? _____

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed): Emily H. Wilson M. D.

(Address): Baltimore, Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Other contributory causes of importance:

	Date of onset
Gallstones	May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	1 week ago

Other contributory causes of importance:

	Date of onset
Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

CERTIFICATE OF DEATH

06694

26

Reg. Dia. No.

1. PLACE OF DEATH:

County.....

Baltimore (Md)

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

4 months 3 weeks 5 days

Hospital, institution, or street address where death occurred:

Baltimore State Hospital

How long in hospital or institution?.....

4 months 3 weeks 5 days

3. (a) FULL NAME

Pleasant Martin

4. Sex

Male

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

widower

6. (b) Name of husband or wife.....

Mrs. known

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

1876

8. AGE:

10

Years

Months

Days

If less than one day

..... hrs. min.

9. Birthplace.....

Maryland
(Town, County, and state)

10. Usual occupation.....

Laborer

11. Industry or business

MOTHER FATHER

12. Name..... Alfred Martin (John)

13. Birthplace..... Md

14. Maiden name..... Eliza Atkins

15. Birthplace..... Md

16. Informant.....

Helen Atkins

Address 577 Preston St.
(Burial, cremation, or removal. Which?)Date thereof 8/3/46
(month) (day) (year)

Cemetery or crematory.....

Mt. Calvary
Location cedar Hill & 7th
Adams Street

18. Funeral director.....

Address 918 E. 3rd Street

19. Date rec'd by registrar 7-31-46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

July 30 1946 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-4-1946 to 7-30-1946 and that I last saw him alive on 7-30-1946

Immediate cause of death.....

generalized arterio-sclerosis

Due to.....

Due to.....

Other conditions..... Senile Psychosis
agitated and depressed type
(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

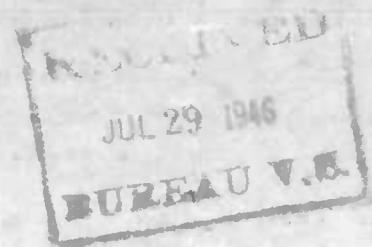
Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

06696

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County

Wings, Brundel

City or town

near Riviera Beach

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

W. Edwin Mitchell

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Mar 27 1898

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

48

hrs.

min.

9. Birthplace

Washington

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date record by registrar

(Date record by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

D.C.

County

Washington

City or town

3227 D St. S.E.

Street No.

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

2. (a) If veteran, name war

World War I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 21 1946 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; Postmortem Examination, as in case

July 22 1946

Immediate cause of death

Drowning

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

7/21/46

Where did injury occur

(City or town)

near Riviera Beach, A.A. Md.

County

(State)

Injured at home, farm, industry, public place (where?)

Story Creek

Means of injury

Drowning

Injured at work?

No

23. SIGNATURE

John M. Laffy, M.D.

Deputy
Medical
Examiner

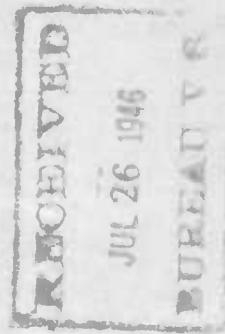
M.D. or other

Address

Annapolis, Md.

Date signed

7/22/46



COPY SENT TO Local Registrar No. 726 DATE 7/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly?

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 956

CERTIFICATE OF DEATH

06697 25
Reg. Dist. No.

1. PLACE OF DEATH:
County..... Anne Arundel County
City or town..... Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death..... 1 yr, 2 mo, 18 days
Hospital, Institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution?..... 1 yr, 2 mo, 18 days

3. (a) FULL NAME
MYERS - MARY LEE LOGAN

4. Sex female 5. Color or race black 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife..... unknown

7. Birth date of deceased (mo. day. yr.) August 26, 1926
6.(c) If alive, give age years

8. AGE: Years 19 Months 11 Days 2 If less than one day
--- hrs. --- min.

9. Birthplace..... Virginia
(Town, county, and state)

10. Usual occupation..... Housework

11. Industry or business.....

FATHER 12. Name..... Frank Logan
13. Birthplace..... Virginia

MOTHER 14. Maiden name..... Justine Pinkney
15. Birthplace..... Georgia

16. Informant..... Hospital Records

Address..... Crownsville, Maryland

17. Buried..... Cemetery or crematory..... Aug. 2 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Mt. Auburn

Location..... Anne Arundel County

18. Funeral director..... Mrs. Katie R. Williams
Address 322 N. Schroeder St., Balto., Md.

19. July 31 1946
(Date rec'd by registrar) *Agnes H. Williams*
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County.....
City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 520 North Stricker Street
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number
unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 28 1946 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 10 1945 to July 28 1946

and that I last saw her alive on July 28 1946

Immediate cause of death.....

Exhaustion

Due to..... Schizophrenia

Due to.....

Other conditions..... Rheumatic Heart Disease

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE

M. D. or other
Crownsville, Maryland Date signed 7/28/46
Address

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1302

CERTIFICATE OF DEATH

06698 21
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

1. PLACE OF DEATH:
 County ANNE ARUNDEL
 City or town FERNDALE
 (If outside city or town limits, write RURAL NEAR and give town)
 Street address, hospital, or institution: 505 N. ANNAPOLIS BLVD
 Stay in hospital or inst. (yrs., or mos., or days) NONE
 Stay in this community (yrs., or mos., or days) 5 MONTHS

3. (a) FULL NAME
ROSA ANNA NORRIS

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced WIDOWED

6. (b) Name of husband or wife HARRY EDWARD NORRIS

7. Birth date of deceased (mo. day, yr.) JANUARY 23, 1886 6. (c) If alive, give age _____ years

8. AGE: Years 66 Months 5 Days 15 If less than one day _____ hrs. _____ min.

9. Birthplace BALTIMORE MARYLAND
 (Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

MOTHER FATHER
 12. Name JOSEPH BERRYMAN
 13. Birthplace GERMANY

MOTHER
 14. Maiden name ELIZABETH (UNKNOWN)
 15. Birthplace BALTIMORE, MARYLAND

16. Informant MRS. EVELYN ANDERSON
 Address 505 N. ANNAPOLIS BLVD.

17. Burial Burial Date thereof 7-11-1946
 (Burial, cremation, or removal. Which? month) (day) (year)

Cemetery or crematory Mt. Olivet

Location Baltimore, Md.

18. Funeral director Flowers & Pleasures
 Address 14 W. Light St.

19. (Date rec'd by registrar) 7-9-1946 Date of death 7-11-1946
 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State MARYLAND County ANNE ARUNDEL
 City or town FERNDALE Ward No. _____
 (If outside city or town limits, write RURAL NEAR and give town)

Street No. 505 N. ANNAPOLIS BLVD (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number _____

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1946, at 8:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 28 1946, to July 8 1946, and that I last saw her alive on July 8 1946.Immediate cause of death UREMIA DURATION _____Due to CHRONIC ARTERIOSCLEROTIC KIDNEYSDue to GENERALIZED ARTERIOSCLEROSISOther conditions CORONARY SCLEROSIS AND ANGINA PECTORIS
 (Include pregnancy within 8 months of death)Major findings:
 Of operations _____
 Of autopsy _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Henry F. Zangara M.D. M. D. or other _____Address 401 W. ANNAPOLIS BLVD. Date signed July 8, 1946

PHYSICIAN

Please underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06699

950

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County

Fairfax

Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

12 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Robert Bentley O'Leary

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

Married

Married

6. (b) Name of husband or wife

Mythi O'Leary

7. Birth date of deceased (mo., day, yr.)

Feb. 13, 1880

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

It less than one day

66

5

6

hrs. min.

9. Birthplace

Philadelphia, Pa.

(Town, county, and state)

10. Usual occupation

Lumberman

11. Industry or business

Lumbermill

12. Name

Terry O'Leary

13. Birthplace

Philadelphia, Pa.

14. Maiden name

Sarah Cooper

15. Birthplace

Tenn.

16. Informant

Mrs. Mythi O'Leary

Address

Fairfax, Md.

17. Burial

Burial

Date thereof

July 20, 1946

(Burial, cremation, or removal. Write

(known) (day) (year)

Cemetery or crematory

Cecil Chapel Cemetery

Location

Springfield, Pa.

18. Funeral director

Bell & Woulton

Address

Fairfax, Md.

19. (Date rec'd by registrar)

July 20, 1946

(Date rec'd by registrar)

July 20, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Anne Arundel

City or town

Fairfax, Md.

Street No.

Camp Meade Rd.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 19, 1946, at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 30, 1946, to July 19, 1946

and that I last saw him alive on July 9, 1946

Immediate cause of death

Congestive heart failure

DURATION

3 months

Due to

Alimentary heart disease

9 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

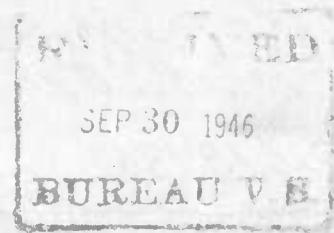
23. SIGNATURE

John Stephens, M.D.

M. D. or other

Annapolis, Maryland Date signed 7/20/46

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20

06700 8

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:

Anne Arundel County

County..... Crownsville, Maryland

City or town..... (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 9 days

3. (a) FULL NAME

PARKER - ROY

4. Sex

Male

5. Color or race

Black

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife.....

unknown

8.(c) If alive, give age unk years

7. Birth date of deceased (mo., day, yr.)

1898

8. AGE:

48

Years

Months

Days

If less than one day

--- hrs.

min.

9. Birthplace.....

Ohio

(Town, county, and state)

10. Usual occupation.....

Chauffeur

11. Industry or business

MOTHER FATHER

12. Name.....

Ematt Parker

13. Birthplace

unknown

14. Maiden name

Julie Atkinson

15. Birthplace

unknown

18. Informant.....

Hospital Records

Address

Crownsville, Maryland

17. Buried

(Burial, cremation, or removal. Which?)

Date thereof July 18, 1946

(month) (day) (year)

Cemetery or crematory Mt. Calvary Cemetery

Location Anne Arundel County, Maryland

18. Funeral director Geo. G. Kelson

Address 1303 Presstman St., Balto., Md.

19. (Date filed by registrar)

7/16/46

19

H. W. Helms

H. W. Helms

Jm Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

County.....

Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 541 Oxford Street

(If rural, give LOCATION)

unknown

2.(a) If veteran, name war.....

3. (b) Social Security Number

unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 14

19 46 at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 6 1946 to July 14 1946

and that I last saw him alive on July 14 1946

Immediate cause of death

Acute Meningitis

DURATION

Known to us since
7/6/46

Due to -----

Due to -----

Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. -----

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. ----- Date of -----

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work? -----

23. SIGNATURE

M. D. or other

Address Crownsville, Maryland Date signed 7/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (134)

CERTIFICATE OF DEATH

06701

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
 City or town Annapolis Neck, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sarah Parker

4. Sex

Female

5. Color or race

colored widow

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife

Samuel Parker

7. Birth date of deceased (mo., day, yr.)

1866

6. (c) If alive, give age years

8. AGE:

Years	Months	Days	If less than one day
80	?	?	hrs. min.

9. Birthplace

Calvert Co.
(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

John Kent

12. Name

John Kent

M.D.

13. Birthplace

John Kent

14. Maiden name

Sarah Reed

15. Birthplace

John Kent

16. Informant

Sarah Jenkins

Address

6 Taylor St. Annapolis Md.

17. Burial

Burial Date thereof July 30 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Annapolis Neck

Location

Annapolis Neck Md.

18. Funeral director

Johnston

Address

Annapolis Md.

19. Date rec'd by registrar

July 29 1946

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel
 City or town Annapolis Neck
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 27 1946 at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 18 1946 to July 27 1946and that I last saw her alive on July 26 1946 to July 27 1946

Immediate cause of death

Ch. nephritis + edema

DURATION

6 mns.

Due to

Due to

Other condition

Smalik
(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

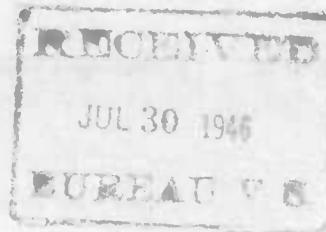
Injured at work?

23. SIGNATURE

M. F. Klarwan, Md.

M. D. or other

Address 31 Somtgat St. Date signed 7/29/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-2

06702

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Anne Arundel

City or town..... Greenland Beach

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Clarence E. Parthas

3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... White married

6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife..... Catharine Parthas

7. Birth date of deceased (mo., day, yr.)..... Dec 5 1888 6. (c) If alive, give age..... years

8. AGE: Years..... 58 Months..... 7 Days..... 29 If less than one day..... hrs. min.

8. Birthplace..... Balti

(Town, county, and state)

9. Usual occupation..... Electress

10. Industry or business.....

11. Father: 12. Name..... Joseph Parthas

13. Birthplace..... Md

14. Maiden name..... Margaret Gerard

15. Birthplace..... Md

16. Informant..... Mrs. Catharine Parthas

Address..... 613 N. Clinton

17. (Burial, cremation, or removal. Which?)..... Burial Date thereof..... July 29/44

(month) (day) (year)

Cemetery or crematory..... Burial Oak Lawn

Location..... Balti Co. Md.

18. Funeral director..... Helen Lunnal Home

Address..... 2008 Orleans St.

19. (Date rec'd by registrar)..... 7/29 1946

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md

County.....

City or town..... Balti

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 613 N Clinton

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

2d. DATE OF DEATH..... July 25 1946

2f. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 16 1946 to July 25 1946 and that I last saw him alive on July 26 1946

Immediate cause of death..... Cardiac failure

DURATION

3-4 yrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE..... J. Brady Smith M.D.

M. D. or other

Address..... Rehobeth Beach, Md.

Date signed..... 7/25/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3d

06703

Reg. Dist. No. 21

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County A.A.

City or town Annapolis, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs.

Hospital, Institution, or street address where death occurred:

17 Jefferson St.

How long in hospital or institution?

3. (a) FULL NAME

Rachel C. Phipps

4. Sex F. 5. Color or race W. 6.(a) Single, married, widowed, or divorced M

6.(b) Name of husband or wife Julius Phipps

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1866

8. AGE: Years 79 Months 9 Days 5 If less than one day hrs. min.

9. Birthplace Maryland A.A. Co. (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name Louise Ford

13. Birthplace Maryland

14. Maiden name Sarah Penny

15. Birthplace Maryland

16. Informant Mr. Louis N. Phipps

Address Annapolis, Maryland

17. Burial Date thereof July 7/46

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory St. James

Location Lethic - and

18. Funeral director Ben L. Hopping & Son

Address 170-172 West St. Annapolis, Md.

19. July 6 1946

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 14 Jefferson St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH July 5, 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1946, to 1946, and that I last saw her alive on 1946.

Immediate cause of death

Ault delatahaz of the Heart

Due to

Due to

Other conditions

Cancer - Ovary - 291-7894

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

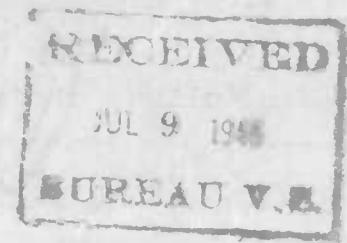
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

06704

8

CERTIFICATE OF DEATH

Reg. Distr. No.

1. PLACE OF DEATH:

County..... *Anne Arundel Co.*City or town..... *Baltimore*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

210 Arundel Rd.

How long in hospital or institution?

3. (a) FULL NAME

*Alice M. Pumphrey*4. Sex *Female* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *widow*6. (b) Name of husband or wife *George W.*7. Birth date of deceased (mo., day, yr.) *May 32, 1867*6. (c) If alive, give age *70* years8. AGE: *78* Years *0* Months *0* Days *0* If less than one day *0* hrs. *0* min.9. Birthplace *Maryland*
(town, county, and state)10. Usual occupation *None*11. Industry or business *None*12. Name *John Hale*13. Birthplace *Md*14. Maiden name *Unknown*15. Birthplace *Unknown*16. Informant *Mr. George J. Hooper*Address *210 Arundel Rd.*17. Burial *Burial* Date thereof *7/16/46*

(Burial, cremation, or removal? Which?)

(month) (day) (year)

Cemetery or crematory *Bedford Hill*Location *Annapolis Blvd*18. Funeral director *John J. Henney Inc.*Address *715 Light St.*19. (Date rec'd by registrar) *7-16-46* *July 16, 1946*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md*County *Anne Arundel Co.*City or town *Baltimore*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *210 Arundel Rd.*

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *July 13th*1946, at *3:00 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Not 1946 to July 1946*and that I last saw her alive on *July 13, 1946*

Immediate cause of death

coronary occlusion

DURATION

Due to *hypertension cardiac**vascular disease*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE *P.W. Kristin M.D.*

M. D. or other

Address *302 Calypso Cr.*(Date signed) *July 16, 1946*

302 Patapsco Ave
(Rev. Keister)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
of deceased is shown on 2411 N. Charles St., Baltimore 460
FILM No. I 06 JUL 31 1946 CERTIFICATE OF DEATH

06705

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Female White Widow

5. Color or race

6. (a) Single, married, widowed, or divorced

8. (b) Name of husband or wife

William Robeck

7. Birth date of deceased (mo., day, yr.)

Oct 11 1878

6. (c) If alive, give age years

8. AGE:

Years	Months	Days	If less than one day
57	68	9	7

hrs. min.

9. Birthplace

Annapolis Md.

(Town, County, and state)

10. Usual occupation

House wife

11. Industry or business

Rasmus Clausen

MOTHER FATHER

12. Name

Jenmark

13. Birthplace

Denmark

14. Maiden name

Elizabeth Dunker

15. Birthplace

Annapolis Md.

16. Informant

Alma C. Robeck

Address

193 Gloucester St. Annapolis Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

St. Mary's

Location

Annapolis Md.

18. Funeral director

John M. Taylor & Son

Address

Annapolis Md.

19. Date rec'd by registrar

July 19 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 193 Gloucester St.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 18 1946 at 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27 1946 to July 18 1946

and that I last saw h. s. alive on July 18 1946

Immediate cause of death

Myocarditis acute with

Myocardial scarring

Due to

Carcinoma of Colon

Due to

Cachexia

Other conditions

Senile

9. months

(Indicate pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

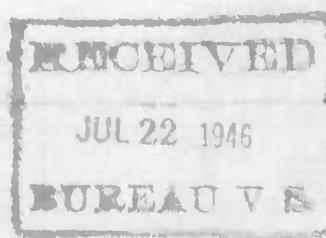
Injured at work?

23. SIGNATURE

George C. Boal M. D. or other

Address Annapolis Md. Date signed July 19 1946

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

CERTIFICATE OF DEATH

Reg. Dist. No. 06728

1. PLACE OF DEATH:
 County..... Anne Arundel County
 City or town..... Crownsville, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 6 months, 20 days
 Hospital, institution, or street address where death occurred:..... Crownsville State Hospital
 How long in hospital or institution?..... 6 months, 20 days

3. (a) FULL NAME
 ROBINSON - ROSALIE

4. Sex..... female 5. Color or race..... black 6. (a) Single, married, widowed, or divorced..... married

6. (b) Name of husband or wife..... James Robinson, Cambridge, Maryland

7. Birth date of deceased (mo., day, yr.)..... 1915

8. AGE: Years..... 31 Months..... unknown Days..... If less than one day
 ---. hrs. ---. min.

9. Birthplace..... Maryland
 (Town, county, and state)

10. Usual occupation..... unknown

11. Industry or business..... unknown

MOTHER FATHER
 12. Name..... unknown
 13. Birthplace..... unknown

MOTHER FATHER
 14. Maiden name..... Netter ?
 15. Birthplace..... unknown

16. Informant..... Hospital Records
 Address..... Crownsville, Maryland

17. Buried..... Cemetery or crematory..... Waugh Cemetery
 (Burial, cremation, or removal. Which?) Date thereof..... July 19, 1946
 (month) (day) (year)

Location..... Cambridge, Maryland

18. Funeral director..... H. M. St. Claire & Son
 Address..... Cambridge, Maryland

19. Date rec'd by registrar..... July 17, 1946
 E. J. Joyce, L. O. L. Registrar
 Date signed..... 7/16/46

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 Maryland State..... County..... Dorchester
 City or town..... Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 65 Park Lane
 (If rural, give LOCATION) unknown
 2. (a) If veteran, name war.....

3. (b) Social Security Number
 unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 16, 1946, at 7:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 26, 1945, to July 16, 1946, and that I last saw her alive on July 16, 1946.

Immediate cause of death..... General Paresis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide. Date of.....

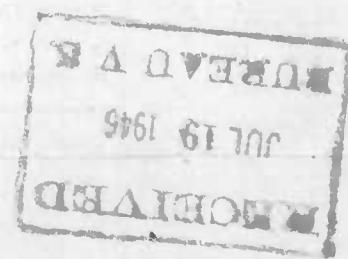
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other.....

Address..... Crownsville, Maryland..... Date signed..... 7/16/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

06708

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County.....

Anne Arundel

Halestville Md

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

39 years

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Lily Sanders

4. Sex

F.

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife.....

Edward Sanders

7. Birth date of deceased (mo., day, yr.)

July 29, 1906

6. (c) If alive, give age..... years

8. AGE: Years

39

Months

11

Days

8

If less than one day

hrs.

min.

9. Birthplace.....

Halestville

(Town, county, and state)

10. Usual occupation.....

House wife

11. Industry or business

Benjamin Brown

12. Name.....

Benjamin

13. Birthplace

Halestville

14. Maiden name.....

Loyce Brown

15. Birthplace.....

Halestville Md

16. Informant.....

Wm Brown

Address

Halestville Md

17. Burial.....

Burial

Date thereof.....

July 10, 1946

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory.....

Halestville Cemetery

Location.....

Halestville Md

18. Funeral director.....

H. A. Sanders & Son

Address

Halestville Md

19. (Date rec'd by registrar)

7/10 1946

Date

M. P. Clayton

Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

City or town.....

Halestville

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

none

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

July 10, 1946, at 11:00

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 30, 1946, to July 7, 1946

and that I last saw him alive on July 6, 1946

Immediate cause of death.....

carcinoma of liver

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

Emily H. Wilson

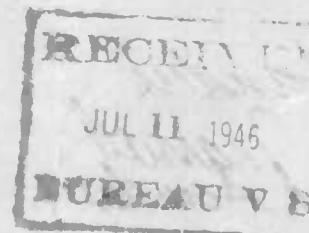
M. D. or other

Address.....

Laurel, Md.

Date signed.....

7/8/46



PLEASE WRITE PLAINLY, WITH UNTADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 25

CERTIFICATE OF DEATH

06709

Reg. Dist. No. 26

1. PLACE OF DEATH:

Anne Arundel County

County Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months, 4 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 7 months, 4 days

3. (a) FULL NAME

SAUNDERS - LOUIS

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

black

married

6. (b) Name of husband or wife Mary Saunders, 213 N.

Arlington Ave., Balto. Md.

6. (c) If alive, give age unk. years

7. Birth date of deceased (mo., day, yr.) May 4, 1904

8. AGE: Years

42

Months

2

Days

7

If less than one day

hrs. min.

9. Birthplace Virginia

(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business unknown

12. Name Beverley Saunders

13. Birthplace Virginia

14. Maiden name Henriette Burden

15. Birthplace Virginia

16. Informant Hospital Records

Address Crownsville, Maryland

17. Buried Cemetery or crematory

Date thereof July 15, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Mt. Calvary

Location Anne Arundel County

18. Funeral director Isiah L. Brown & Son

Address 108 W. Montgomery St., Balto., Md.

19. 7-16 1946 Duffleder Registrar
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

State County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 213 North Arlington Avenue

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number
unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11

19 46 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 7

19 45 to July 11

19 46

and that I last saw h. im alive on July 11

19 46

19 46

Immediate cause of death

Post-Epilepsy in Bellary

DURATION

Known to us since 12/7/45

Due to

Due to

Other conditions Post-traumatic Epilepsy

with Psychosis

(Include pregnancy within 3 months of death)

Known to us since 12/7/45

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

M. D. or other

Address Crownsville, Maryland

Date signed 7/11/46

Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (HB)

06710

CERTIFICATE OF DEATH

Reg. Diet. No.

23

1. PLACE OF DEATH: Anne Arundel
 County: County
 City or town: Pasadena
 (If outside city or town limits, write RURAL and give nearest town)

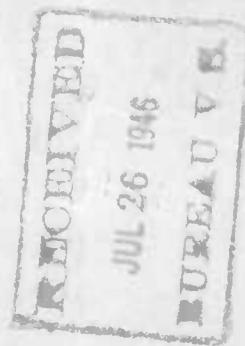
How long in above place of death? 4 years
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 Maryland County: County
 City or town: Pasadena
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Old Annapolis Rd.
 (If rural, give LOCATION)

3. (a) FULL NAME: Mrs. Mary Catherine SCHULTZ

4. Sex: F. Color or race: white 5. (a) Single, married, widowed, or divorced: Married
 6. (b) Name of husband or wife: Joseph Charles Schultz
 7. Birth date of deceased (mo., day, yr.): Sept 1-1895 6. (c) If alive, give age: 56 years
 8. AGE: Years: 50 Months: 10 Days: 20 If less than one day: hrs: min:
 9. Birthplace: Harford County, Md. (Town, county, and state)
 10. Usual occupation: Housewife
 11. Industry or business: Charles St. Kress
 12. Name: Maryland
 13. Birthplace: Maryland
 14. Maiden name: Mary Weilick
 15. Birthplace: Maryland
 16. Informant: J. E. Schultz - husband.
 Address: Pasadena, Md.
 17. Burial: Date thereof: July 22, 1946
 (Burial, cremation, or removal? Which?) Cemetery or crematory: GLEN HAVEN
 Location: GLEN HAVEN, MD
 18. Funeral director: Thomas W. Daigler
 Address: Glen Burnie, Md.
 19. Date rec'd by registrar: July 23, 1946 Mr. Dealee
 (Date rec'd by registrar) Registrar: Dealee

3. (b) Social Security Number:
 MEDICAL CERTIFICATION
 2D. DATE OF DEATH: July 20, 1946, at 2:15 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 to July 20, 1946, and that I last saw her alive on July 20, 1946.
 Immediate cause of death: Coronary heart disease
 DURATION: 1 day.
 Due to: Cancer of the stomach
 Due to:
 Other conditions:
 (Include pregnancy within 3 months of death)
 Major findings of operations:
 Date of op:
 Autopsy results:
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide: Date of:
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, Industry, public place (where?)
 Means of injury: Injured at work?
 23. SIGNATURE: Gustave A. Baekersius.
 M. D. or other:
 Address: Glen Burnie, Md. Date signed: 7/20/46



COPY SENT TO ~~COL~~ ^{Co.} REGISTRAR DATE 7/26/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4720

06711

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County Anne Arundel

City or town Harwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yrs

Hospital, institution, or street address where death occurred:

Harwood, Md.

How long in hospital or institution?

3. (a) FULL NAME

George Hildt SHEPHERD

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Sallie N.

7. Birth date of deceased (mo., day, yr.)

Oct. 29, 1872

6. (c) If alive, give age 58 years

8. AGE: Years

73

Months

8

Days

24

If less than one day

— hrs.

min.

9. Birthplace

Mt. Zion, A.A. Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name

Owens Shepherd

MOTHER

13. Birthplace

Maryland

14. Maiden name

Kate Hildt

15. Birthplace

Maryland

16. Informant

Mrs. Sallie N. Shepherd

Address

Harwood, A.A. Co. Maryland

17. Burial

Date thereof July 24, 46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Mt. Zion Cemetery

Location

Lothian Maryland

18. Funeral director

Ben L. Horning & Son

Address

170-172 West St. Annapolis, Md.

19. (Date rec'd by registrar)

19

7/24 1946

D.W. Clayton

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Anne Arundel

City or town Harwood

(If outside city or town limits, write RURAL and give nearest town)

Street No.

F.O.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 22, 1946, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-22, 1946, to 3-22, 1946

and that I last saw him alive on 3-22, 1946

Immediate cause of death

circulatory failure

Due to carcinoma of lungs?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

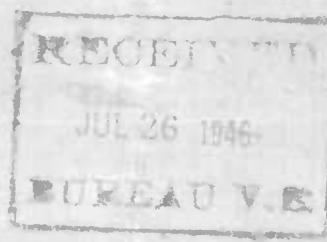
Means of Injury

Injured at work?

23. SIGNATURE

Edith Roller M.D.

(Date signed) 7-23-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

06712-20

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Anne Arundel

County

Lanark

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Josephine Shepherd

4. Sex

F

5. Color of race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Oct 16, 1888

6. (c) If alive, give age

years

8. AGE: Years

63

Months

9

Days

5

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

Bristol Md

10. Usual occupation

(Town, county, and state)

Housekeeper

11. Industry or business

(Town, county, and state)

John Shepherd

MOTHER FATHER

12. Name

(Town, county, and state)

John Shepherd

13. Birthplace

(Town, county, and state)

Rural

14. Maiden name

(Town, county, and state)

Mary Lucy Smith

15. Birthplace

(Town, county, and state)

Bristol Md

16. Informant

(Town, county, and state)

Ashley Shepherd

Address

(Town, county, and state)

Bristol Md

17. Burial

(Burial, cremation, or removal? Which?)

Date thereof

Aug 23 1946

(month) (day) (year)

Cemetery or crematory

(Town, county, and state)

Mt Oliv Cemetery

Location

(Town, county, and state)

Lothian Md

18. Funeral director

(Town, county, and state)

J. A. Spangler

Address

(Town, county, and state)

Salisbury Md

19. Date rec'd by registrar

(Date rec'd by registrar)

Aug 1st 46

1946

St. M. Day to

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Md.

City or town

Bristol

County

Lothian

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 23 1946

30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 18 1946 to Aug 23 1946

19

and that I last saw her alive on Aug 18 1946

46

Immediate cause of death

Myocarditis Obstructive

2

Due to

Poly Arthritis

2

Due to

Other conditions

?

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

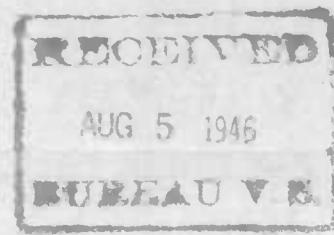
F. B. F. West M.D.

M. D. or other

Address

Lothian Md Date signed 8-1-46

M. D. or other



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

06713

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred.....

How long in hospital or institution?.....

3. (a) FULL NAME

Christina Smith

4. Sex

female

5. Color or race

negro

6. (a) Single, married, widowed, or divorced

widow

6. (b) Name of husband or wife.....

William

7. Birth date of

deceased (mo., day, yr.)

deceased (mo., day, yr.)

8. (c) If alive, give age.....

years

8. AGE: Years

59

Months

md

Days

0

If less than one day

hrs. 0

min. 0

9. Birthplace.....

(Town, county, and state)

Md

10. Usual occupation.....

Domestic

11. Industry or business

12. Name.....

James Hardy

13. Birthplace.....

Md

14. Maiden name.....

James Smith

15. Birthplace.....

Md

16. Informant.....

James Smith

Address

1126 N. Calhoun St

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

Md

18. Funeral director.....

Geo. W. Kelsay

Address

1303 Prussia St

7-24-46

Autumn

19. (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Baltimore

City or town.....

1659 Stages Ave

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1659 Stages Ave

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

July 27

1946

at

6

P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 23

1946

and deceased died on

July 23

1946

immediate cause of death.....

Coronary occlusion

DURATION

Due to.....

Coronary sclerosis

untrm

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

John M. Coffey, M.D.

Medical

Examiner

M.D. or other

Address.....

Annapolis, Md.

Date signed

7/23/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 307

CERTIFICATE OF DEATH

Reg. Dist. No. 26

06714

1. PLACE OF DEATH:
 County..... Anne Arundel County
 City or town..... Crownsville, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 11 days
 How long in above place of death?
 Hospital, Institution, or street address where death occurred:
 Crownsville State Hospital
 11 days
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

Md.

State..... County.....
 City or town..... Balto.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 812 Whatcoat St.
 (If rural, give LOCATION)

3. (a) FULL NAME
 STEVENSON - THOMAS

3. (b) Social Security Number

4. Sex male	5. Color or race black	6. (a) Single, married, widowed, or divorced married
----------------	---------------------------	---

8. (b) Name of husband or wife.....
 Cora Stevenson, 812 Whatcoat
 St., Baltimore, Md. 8. (c) If alive, give age..... unk. years
 7. Birth date of
deceased (mo., day, yr.) 1910

8. AGE: Years 36	Months unknown	Days —	If less than one day —. hrs. —. min.
---------------------	-------------------	-----------	---

9. Birthplace..... unknown
 (Town, county, and state)

10. Usual occupation..... unknown

11. Industry or business..... unknown

FATHER 12. Name..... unknown

13. Birthplace..... unknown

14. Maiden name..... unknown

MOTHER 15. Birthplace..... unknown

16. Informant..... Hospital Records

Address..... Crownsville, Maryland

17. Buried..... Date thereof..... July 21, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Mt. Calvary
 Location..... Anne Arundel County

18. Funeral director..... Geo. G. Kelson

Address..... 1303 Presstman St., Baltimore, Md.

19. Date rec'd by registrar..... 7-19 1946
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 18, 1946, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 8, 1946, to July 18, 1946,
 and that I last saw h. alive on

Immediate cause of death..... Cerebral Hemorrhage
 DURATION 10 days

Due to..... Syphilis
 unknown

Due to.....

Other conditions..... General Paresis (?)
 (Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Crownsville, Maryland Date signed 7/18/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1310

06715

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County

City or town Freetown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Sarah F. Stewart

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F C W

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

2/14/1885

6. (c) If alive, give age years

8. AGE: Years

Months

Days

If less than one day

61 4 23 hrs. min.

9. Birthplace

Marley Neck

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Jacob Frank Clin

12. Name

Md

MOTHER FATHER

13. Birthplace

Henrietta Curry

14. Maiden name

Md

15. Birthplace

Hiram Stewart

16. Informant

Freetown a. a. co. Md.

Address

Burial

Date thereof 7-11-46

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Hallie memorial

Cemetery or crematory

a. a. co. Md

Location

Isaiah L Brown & Son

Funeral director

108 W Montgomery St

Address

7-11 46

Date rec'd by registrar

7-11 19

Registrar

Signature

M. D. or Other

Date signed

7/19/46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MdCounty a. a.

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No. Freetown

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 8 1946

at 9:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/8/46 to 7/8/46

19 19

and that I last saw her alive on 7/6/46 19

19

Immediate cause of death

Cerebral hemorrhage

DURATION

2 days

Due to

Chronic Lutein Megatherus

Other

Adams syndrome

and

Acute

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John Maynard

M. D. or Other

Address

John Brown

Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

06716

CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH:

County: Alb CoCity or town: Cedar Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? _____

Hospital, Institution, or street address where death occurred: _____

How long in hospital or institution? _____

3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

Teresa

7. Birth date of deceased (mo., day, yr.)

July 6, 1873

6. (c) If alive, give age 73 years

8. AGE:

Years 73

Months

Days

If less than one day

..... hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Supt

11. Industry or business

Cedar Hill Cem.

John Utz Jr.

12. Name

John Utz Jr.

13. Birthplace

Bucktown Penn.

14. Maiden name

Bucktown Charlotte Brown

15. Birthplace

Bucktown Baltimore Md.

16. Informant

Mr. John E. Utz

Address 5704 Magic St.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 7/18/46

(month) (day) (year)

(month) (day) (year)

Cemetery or crematory

Cedar Hill

Location Armaghais Blvd

18. Funeral director

John F. Henning Jr.

Address 715 Bright St.

19. Date rec'd by registrar

7-18-46

Signature John F. Henning Jr.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MdCounty: Alb CoCity or town: Cedar Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No. Citeline Highway

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 15, 1946, at 4:20 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 15, 1946, to July 15, 1946.

and that I last saw him alive on July 14, 1946.

Immediate cause of death Coronary Spasms

DURATION

2 yrs

Due to Coronary Spasms

Due to _____

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____

Date of

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, Industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Thos. H. Phillips

M. D. or other

Address 1939 Edmonds St.Date signed 7-16-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 182

06717

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County - Anne Arundel
City or town - Green Haven, P.O. Pasadena

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? - 1 1/2 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Carol Catherine Stallon

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F.

W.

S.

8. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

33 (c) If alive, give age

years

May 23 - 1946

8. AGE: Years

Months

Days

If less than one day

1 16 hrs. min.

9. Birthplace

Green Haven, Md

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

James O. Stallon

12. Name

James O. Stallon

13. Birthplace

Baltimore, Md

14. Maiden name

Edith M. Shackle

15. Birthplace

Baltimore, Md

16. Informant

The parents

Address

Green Haven, Md

Burial

(Burial, cremation, or removal. Which?)

Date thereof July 9, 1946

(month) (day) (year)

Cemetery or crematory

Mt. Carmel Church yard

Location

A. A. S. Rd. (Mountain Road)

18. Funeral director

Thomas W. Burdett

Address

Green Haven, Md

19. Date rec'd by registrar

July 8, 1946

Date of death

Medalba

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

D.A.

City or town

Md. Pasadena

(If outside city or town limits, write RURAL and give nearest town)

Street No.

16 street - Green Haven

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 7, 1946, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....

to 19.....

and that I last saw him alive on 19.....

19.....

Immediate cause of death.....

Suffocation -

Baby slept between father

and mother - and was

found dead - by parents

when they woke up.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

7/7/46

Where did injury occur? Green Haven, Md.

County

Md.

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury.....

Injured at work?

23. SIGNATURE

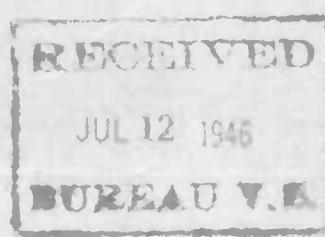
after medical examination

M. D. or other

Address: Green Haven, Md.

Date signed

7/7/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

06718

P

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County Anne Arundel
 City or town Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Joseph R. Wampler

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Mary Jane Hawkins

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 30, 1872

8. AGE:

13

Years

Months

Days

If less than one day

hrs.

min.

B. Birthplace

Md.

(Town, county, and state)

10. Usual occupation

Petried

11. Industry or business

Francis Wampler

MOTHER FATHER

12. Name

Francis Wampler

13. Birthplace

Md.

14. Maiden name

Francis Bowers

15. Birthplace

Md.

16. Informant

Anna B. Fields

Address

202 Fifth Avenue

Burial

(Burial, cremation, or removal, which?)

Date thereof July 13, 1946

(month) (day) (year)

Cemetery or crematory

Location

John F. Lenny Inc.

18. Funeral director

Address

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20

CERTIFICATE OF DEATH

06719

231

Reg. Dist. No.

1. PLACE OF DEATH:

County.

City or town.

Anne Arundel
Shoreham Beach Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Evelyn Bell Waters

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F. White Married

6. (b) Name of husband or wife

Joseph L.

7. Birth date of deceased (mo., day, yr.)

7-18-1883

6. (c) If alive, give age 72 years

8. AGE:

Years
63

Months

Days

If less than one day

hrs. min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

Cornelius H. Helm

FATHER

12. Name

Virginia

MOTHER

13. Birthplace

Virginia

14. Maiden name

Fannie B. Triplett

15. Birthplace

Virginia

16. Informant

Mrs. J. P. Waters

Address

1415-9 st. S.E.

17. Cedar Hill

Date thereof 7-22-46
(Burial, cremation, or removal. Which?)
(month) (day) (year)

Cemetery or crematory

Cedar Hill Cemetery

Location

18. Funeral director

J. William Lee Long

Address

300-4 st. N.E.

19. July 20, 1946

(Date rec'd by registrar)

Amanda Downey
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Anne Arundel
Shoreham Beach Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

City or town

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1946 at 3:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 24 1946 to July 19 1946

and that I last saw her alive on July 18 1946

Immediate cause of death

Generalized carcinomatosis

DURATION

24 hr.

Due to Cancer of the breast

3 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

S. Bowers M.D.

M. D. or other

Annapolis Md. Date signed 7/25/46



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

06720-20

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or Town.....

Anne Arundel
Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Life

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Elizabeth White

4. Sex

F

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

George White

7. Birth date of deceased (mo., day, yr.)

Feb 1 1889

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

57 5 26

hrs. min.

9. Birthplace.....

Salisbury

(Town, county, and state)

10. Usual occupation.....

House work

11. Industry or business

MOTHER FATHER

12. Name.....

Elizabeth Booye

13. Birthplace.....

Salisbury

14. Maiden name.....

Martha Ann Booye

15. Birthplace.....

Salisbury

16. Informant.....

Elizabeth White

Address.....

Salisbury Md

17. Burial.....

Burial

Date thereof July 30 1946
(month) (day) (year)

Cemetery or crematory.....

Cemetery

Location.....

Salisbury Md

18. Funeral director.....

J. A. Stanley & Son

Address.....

Salisbury Md

19. (Date rec'd by registrar)

July 30 1946

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Anne Arundel

City or town.....

Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

None ✓

3. (b) Social Security Number

None ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 30 1946, at 5 P.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

July 30, 1946, to July 27, 1946.

and that I last saw her alive on July 27, 1946.

Immediate cause of death.....

Heart Failure

Due to.....

Chronic myocarditis

Due to.....

Other condition.....

Cerebral - Sclerosis

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE

R. P. Rehwald M.D.

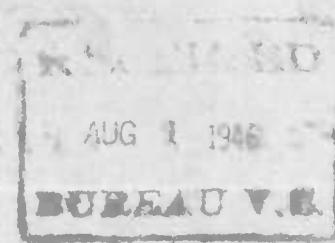
M. D. or other

Address.....

Burwash, Md

Date signed.....

SNOW
SNOW



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

06721

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County Anne Arundel
City or town Maryland Park, P.O. New Burnie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years
Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Minnie Estelle Wood4. Sex F 5. Color or race W. White 6. (a) Single, married, widowed, or divorcedB. (b) Name of husband or wife William C. Wood7. Birth date of deceased (mo., day, yr.) August 22 1871 6. (c) If alive, give age dead years8. AGE: Years 74 Months 11 Days 0 If less than one day hrs. 0 min.9. Birthplace Kent County, Maryland
(Town, county, and state)10. Usual occupation housekeeping

11. Industry or business

MOTHER FATHER
12. Name Robert Dauney
13. Birthplace Maryland14. Maiden name Mary Elizabeth Dowling
15. Birthplace Maryland16. Informant Woman Hodges (son)
Address Maryland Park, P.O. New Burnie, Md.17. Burial Burial
(Burial, cremation, or removal. Which?) Glen Haven
Cemetery or crematoryLocation Glen Burnie, Md
18. Funeral director Thomas W. Singleton
Address New Burnie, Md19. July 23 1946 Wife Alba
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel
City or town Maryland Park, P.O. New Burnie, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. The Seasideway
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1946, at 12:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946, to July 22 1946, and that I last saw her alive on July 21 1946.Immediate cause of death arterial hemorrhage DURATION 4 daysDue to Hypertension DURATION 2 yearsDue to Senility DURATION 3Other conditions (Include pregnancy within 3 months of death)Major findings of operations Date of op. Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE Gustave H. Fuerthius M. D. or other Address Glen Burnie, Md Date signed 7/25/46

